impulse being in the fifth left interspace, below and slightly external to the nipple. There was a well-marked mitral systolic murmur which was to be heard distinctly in the back of the same side. His previous illnesses were measles and (?) scarlet fever, the latter when he was about three years of age, and the medical man in attendance then is said to have remarked that it had affected his heart. Nine months previously I had refused to pass him into a friendly society on account of his having a systolic murmur at the apex.

I had the joints covered with cotton-wool and flannel. I also advised bathing his chest and head with tepid water and gave him a mixture containing 10 grains of sodium salicylate, 10 grains of potassium bicarbonate, and four minims of tincture of digitalis, to be taken every four hours, and two teaspoonfuls of brandy, also every four hours. By April 1st his temperature had dropped to 100°, his pulse was 90, and his respirations were 30. No other joints had been affected in the meanwhile, but those that were had considerably lessened in size and he was suffering from no pain. On examination of the heart I found it to be considerably increased in size, reaching to the right of the right border of the sternum, above nearly to the lower borders of the second ribs, and practically as before on the left side. Friction sounds were to be heard over this area. By the 3rd the joints were normal in size and painless and the sweating had subsided, but the temperature had risen to 103·2°, the pulse was 120, and the respirations were 40. The urine was diminished in quantity to 44 ounces in 24 hours. I stopped the sodium salicylate and substituted 30 grains of diuretin every four hours. The brandy was continued and the bathing was stopped. The patient was kept propped up in bed almost at right angles to it, as otherwise orthopnœa was so pronounced. During the next five days, with occasional small doses of antifebrin, the temperature dropped to 101°, but there were no signs of absorption of the effusion taking place. I ordered the chest to be painted once daily with tincture of iodine (half strength) and gave three grains of iodide of potassium every four hours. By the 12 h the area of cardiac dulness was markedly diminished; the temperature was 99·4° in the morning and 100·2° in the evening. The urine had now reached about 60 ounces daily. The painting of the chest with iodine and the administration of iodide of potassium were stopped, as an iodide rash had appeared. On the 20th the patient's temperature was normal and remained so, and his heart had resumed its normal size. He was, of course, still kept in bed and all available and suitable nourishment was administered. In the beginning of June the parents particularly wished him to be taken home. A carriage and pair was kindly lent and he was placed on a stretcher and put in it and taken at a walking pace. A few days afterwards I was fetched early in the morning to him and found that he had commencing signs of backward pressure from the heart failing. The lungs were congested at the bases, the liver was enlarged, and there was œdema of the legs, ankles, and feet. I gave him a hypodermic injection of one-hundredth of a grain of strychnine sulphate and ordered half a wine-glassful of champagne every two hours. The next day he seemed much better and was ordered a mixture of digitalis and an alkaline aperient. Then he developed a sudden swelling of the left forearm and hand with simple phlebitis, probably due to thrombosis of the axillary vein, the right arm being quite normal in size. In the course of 10 days this got better, but otherwise he became gradually worse and he died on June 26th.

Now that there is so much discussion on the classification of acute rheumatism it seems worth while drawing attention to the coincidence of two members of the same family being affected at the same time. Although not living in the same house the deceased had visited his brother frequently before he had to take to his bed. I believe it is not a common occurrence to recover from pericarditis when there is a previous diseased condition of the valves of the heart.

Blagdon, near Bristol.

A CASE OF COMPLETE INVERSION OF THE UTERUS.

By DAVID DURRAN, M.B. GLASG.

OWING to its great rarity the following case of complete inversion of the uterus ought to be placed on record. According to Playfair this accident was only observed once in upwards of 190,800 deliveries at the Rotunda Hospital since its foundation in 1745. Various explanations have been given to account for its production. In the present case there was a suspicion that pressure on the abdomen was improperly applied, but the midwife who was in attendance would not admit that there was undue pulling on the cord. The case was as follows.

On Jan. 30th, 1899, I was called to a woman in labour. On my arrival I found her in bed, pale, with a small and feeble pulse, cold clammy skin, and evidently suffering from shock. The midwife informed me that a little over an hour before a child was born and that along with the after-birth something came down the like of which she had never seen before but which she thought was the womb. This she returned. There was great loss of blood and the patient had been in a fainting condition ever since. It may be mentioned here that the patient was 25 years of age, strong, and in good health. She had been married seven years and this was her third child. On examination I discovered a large globular mass of the consistence of muscle tissue filling the vagina and bleeding profusely. Bimanual examination showed the absence of the contracted uterus and instead a cup-shaped depression was easily felt, which made out the case to be one of complete inversion of the uterus. Manipulation restored the organ in a few minutes to its natural condition. The inverted uterus was first firmly grasped by the hand and gently squeezed, being at the same time pushed slightly upwards. The tips of the fingers were then applied to the fundus and by steady pressure in the proper axis of the pelvis the uterus was felt to resume its natural shape. The patient made a good recovery and everything went on well until the eleventh day after the confinement, when delusions showed themselves, and in a few days the case developed into one of acute puerperal mania presenting the usual symptoms, which necessitated asylum treatment. There was evidence of hereditary tendency, but the determining cause at that time was no doubt the shock from the accident referred to as well as exhaustion from the great loss of blood. After several months in the asylum the patient returned home and is now in very good health.

Thurso, Caithness.

UNUSUAL CONDITIONS AT BIRTH.

By A. J. RICE OXLEY, M.A. OXON., M.B. DUB., M.R.C.S. ENG.

CASE 1. *Fracture of the clavicle; normal presentation.*—A patient of mine was delivered of her third child a short time ago. At my visit the following day the nurse asked me to look at a "sharp hard swelling at the top of the right side of the chest." On examination I found that the infant had a fractured clavicle. Delivery had been very rapid—so rapid that I was unable to arrive in time; but the nurse, a skilful one, assured me that she had in no way interfered during the progress and that it was normal in every way "except for its being very quick indeed." Such an occurrence is, of course, not very remarkable in some cases of difficult labour, but is surely very unusual in a case of the above-mentioned type. I may add that union was quite satisfactory.

CASE 2 *Congenital thickening of the sterno-mastoid* — Shortly after delivery (by forceps) the nurse called my attention to a lump at the side of the neck of the infant. I had exercised comparatively little traction and diagnosed the case as "congenital swelling of the sterno-mastoid." This thickening was not a hæmatoma I am sure, and has now almost disappeared without any limitation of movement. I gave small doses of grey powder, but as the tendency of these thickenings is to clear up by themselves it is impossible to ascribe any definite effect to this preparation.

Streatham, S.W.

PROPOSED BACTERIOLOGICAL LABORATORY.—The sanitary committee of the Plymouth Corporation have decided to approach the Devon and Cornwall County Councils and the Stonehouse District Council in reference to the formulating of a scheme for the establishment of a joint county and municipal bacteriological laboratory in conjunction with the borough of Plymouth.

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

UNIVERSITY COLLEGE HOSPITAL.

A CASE OF TETANUS; SUBDURAL INJECTION OF ANTI-TETANIC SERUM; RECOVERY.

(Under the care of Mr. A. E. BARKER.)

IN the present state of our knowledge as to the therapeutic value of the intracranial injection of anti-tetanic serum it is very desirable that as many cases as possible of this ingenious treatment should be put on record. The injection of the serum into the subdural space is simpler and less likely to do harm than the injection into the brain substance, and therefore is to be preferred if it seems to be equal in efficacy. Of 25 cases that have been recorded of treatment by intracranial injections, 14 patients died and 11 recovered.[1] For the notes of this case we are indebted to Mr. Percy Stedman, house surgeon.

A man was admitted into University College Hospital under the care of Mr. Barker on May 4th with the following history. 14 days previously he went into his yard, slipped down, and cut the side of his head. A friend washed the wound for him with Condy's fluid and bandaged it up. He felt little the worse for the fall and went on with his work as usual until May 1st. On this day he felt that his neck was getting stiff and he experienced a curious sensation of something crawling up the back of his neck; he saw his medical adviser who sent him to bed. On the next day the stiffness at the back of the neck had increased and the head was twisted to the left side. The following day the jaw and also the back of the legs began to get stiff. He had no twitchings or convulsions.

On admission, on the right side of the head, over the lower and posterior part of the parietal bone, was a wound through the skin, about one square inch in size. It had a distinctly sloughy appearance and around it there was a large amount of œdema. He complained of pain and stiffness at the back of his neck and of inability to open his mouth; he could not turn his head to the right, neither could he raise himself from the bed. The back was arched and the legs were rigid; he perspired very freely, being covered with beads of sweat. On making an effort the patient was able to open his teeth to the extent of a quarter of an inch; through this a small indiarubber tube had been inserted by which the patient was fed with milk. The arms were unaffected, the thorax and abdomen moved well on respiration, but the abdominal muscles were rather hard. The pulse, respiration, and temperature were normal.

In the absence of Mr. Barker from town Mr. Victor Horsley decided to inject anti-tetanic serum. The head was shaved over the parietal bone and the sloughy wound was excised. The skull was trephined with a quarter-inch trephine and the needle of the injection syringe was passed into the sub-dural space and seven and a half cubic centimetres of anti-tetanic serum, prepared at the Jenner Institute, were injected. Whilst the patient was under the anæsthetic the spasm of the muscles only showed slight tendency to relax. During the following four days 20 cubic centimetres of serum were injected into the flanks. The abdomen became very rigid and the right arm also became rigid. Gradually increasing doses of chloral had been administered to the patient since his admission until he was taking 80 grains per diem; this was continued.

No improvement took place for a week when the rigidity of the muscles of the neck and abdomen began to pass off. From this time onward the patient made an uninterrupted recovery, the rigidity passing from the legs last, and at the end of three weeks from his admission into the hospital all the stiffness had passed off.

[1] Practitioner, 1899, vol. ii, p. 80.

ROTHERHAM HOSPITAL.

A CASE OF TUBAL GESTATION WITH RUPTURE IN A WOMAN PREVIOUSLY OPERATED UPON FOR TUBAL GESTATION WITH MISSED LABOUR.

(Under the care of Mr. J. B. LYTH.)

ONE of the more frequent causes of sterility in women is an obstruction to the passage of the ovum along the Fallopian tube. If this obstruction be bilateral and complete the sterility is absolute, but if it be unilateral, or not complete, fertilisation may occur. This is then especially likely to take place in the Fallopian tube, for the spermatozoon can pass through an opening which is too small to allow the passage of an ovum. For the notes of the case we are indebted to Dr. J. S. Martin, house surgeon.

A married woman who had had one child born dead 10 years previously was admitted into the Leeds Infirmary in November, 1892, under the care of Dr. James Braithwaite, to whose courtesy Dr. Martin is indebted for an account of her case while there. She had a history of 10 months' pregnancy. There was no history of rupture of the sac. After nine months the child appeared to have died. On Nov. 30th an operation was undertaken and a large full-grown dead child was removed. It lay in a cyst which was an expanded portion of the left broad ligament. The placenta was attached to its posterior wall and was removed. The edges of the cyst were stitched to the peritoneum, the cavity was drained, and the patient made a good recovery. She had no further pregnancies and remained well until six weeks before her admission to the Rotherham Hospital. She had some irregular hæmorrhages and these in the light of her previous experience she regarded as evidence that she was again pregnant. She thought that she would be three or four months gone. Six weeks before admission she had an attack of abdominal pain with collapse, sickness, and jaundice. The attack lasted a couple of days. She had six attacks before her admission. On May 22nd, 1900, and on the morning of the 23rd she had another attack. She was in great pain and her blanched lips and feeble pulse indicated internal hæmorrhage. Her temperature sank to 96° F. An injection of strychnine was given and a quarter of an hour afterwards she rallied. The pain and sickness continued through the day. On the following day (May 24th) she was better and it was possible to make an examination of the abdomen. There was a tumour reaching well above the umbilicus and lying medially but somewhat inclined to the right. The scar of the previous operation lay to the left of the umbilicus. In the afternoon she had another attack similar to that of the 23rd. She recovered again and on the 26th she was so much better that Mr. Lyth proceeded to operate.

An incision was made, starting from a point one inch below and to the right of the umbilicus, and continued downwards for about three and a half inches. On opening the peritoneum a mass of blood-clot came into view. Mr. Lyth passed his hand first around and then through this and his hand entered the sac. Placental tissue and a piece of umbilical cord four inches in length were found, but no fœtus. The pregnancy was in the fimbriated end of the right Fallopian tube or between it and the ovary. The sac had in the course of its growth become adherent to the omentum, the wall of the pelvis, the small intestine, and the posterior part of the body of the uterus. The uterine end of the Fallopian tube had become adherent to the sac. Between this and the fimbriated extremity there was a free loop. The placenta lay upon the upper surface of the sac. The site of the rupture could not be discovered. Before a pedicle could be made it was necessary to remove the placenta. After this all the free portions of the sac were cut away. Two portions of the sac were so closely adherent to the omentum and the pelvic wall that it was necessary to leave them. From the size of the sac the pregnancy was about the fifth month. During the operation the patient lost a good deal of blood and saline infusion was resorted to. A glass drainage-tube was inserted and the wound was closed.

The patient made a good recovery. The wound was syringed daily with a solution of boroglyceride (1 in 20). There was diarrhœa from May 30th to June 2nd, which was